HIPAA CONSENT FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO OUR PATIENTS:

Patient information will be maintained by The Motive as described by the Notice of Privacy Practices contained in the Corporate Compliance Program and in compliance with federal and state regulation. You may obtain a copy of the Notice of Privacy Practices by contacting the Office Manager.

The Motive reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. We will release information related to any work related injury to your employer. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy.

We reserve the right to:

- Call you to remind you of your next appointment and/or leave information on your answering machine.

- Call you with lab and/or test results and leave information on your answering machine.

  At what number(s) would you like to be contacted? _____-_____-_____

If there is anyone that you would like us to share your health information with, please list the names below:

I have read and understand my rights.

_____ _____ _____
Signature of patient or legal guardian Date Signature of witness

_____ _____
Print the name of the patient DOB/Acct #